DEATH AND CONTEMPORARY MAN: A STUDY OF PATIENT, FAMILY AND PASTOR IN THE CONTEXT OF THE TERMINAL SETTING

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So we do not lose heart. Though our outer nature is wasting away, our inner nature is being renewed every day. For this slight momentary affliction is preparing for us an eternal weight of glory beyond all comparison, because we look not to the things that are seen but to the things that are unseen; for the things that are seen are transient, but the things that are unseen are eternal.

- II Corinthians 4: 16-18

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CHAPTER I

INTRODUCTION

The purpose of this study is to critically investigate and examine the variant reactions of patient, family and pastor to the manifold problems arising in the context of the terminal setting, in light of the general contemporary attitude which represses and covers over the fact of death due to its frustrating finality. Not only will we seek to understand the behavioral patterns and attitudes of those who are faced with the imminence of death, whether this be their own or that of someone else, but also, we will seek to better comprehend the interrelated needs of patient, family and pastor in the context of the terminal setting, to the end that all who face the crisis of terminal illness may be more adequately prepared to deal with the many frustrations, anxieties and responsibilities which arise when the hand of death comes to be felt in the immediacy of one's present life.

That such a study as this is justified stems from four pertinent reasons. First, as there is today a contemporary cultural endoctrination "against" the discussing of death in any of its ramifications, it is important to bring this subject into "open view" in that there comes a time in each man's life, whether he like it or not, when the fact of

death must be met. Secondly, as the fact of death, even when consciously acknowledged and discussed, never ceases to give rise to feelings of nervous anxiety, frustration and impending doom, it is important that each man "prepare" for his death, both materially and spiritually, to the end that his last days may be frought with less worry, fear and trepidation. Thirdly, as any man's accomodation to terminal illness and death is never easy, it is important that all who are faced with the crisis of the terminal setting be informed regarding the external and internal manifestations in their behavioral attitudes and needs which spontaneously arise from personal identification in and with death. And finally, while there have appeared in recent years a number of fine investigations dealing with the "terminal patient," such as Ministering to the Dying by Carl Scherzer, Counseling the Dying by Margaretta Bowers et. al., and "Ministering to the Dying" by Rollin Fairbanks, it should be noted, on the other hand, that relatively little material has been published dealing with family's reaction to the crisis of the terminal setting or the problems faced, personally, by the pastor in the context of his "terminal ministry." Thus, it is one of the aims of this study to attempt to shed some further light into this generally neglected but important area. What is more, as no investigation to date has yet attempted to bring together the problems faced in the terminal

setting by patient, family and pastor, in light of their interrelationship within the Christian family or in regard to contemporary attitudes toward death, it is the general aim of this study to bring into a "unified" focus many of the problems arising in the face of death which have been, until the present time, discussed "solely" in terms of patient, family or pastor, neglected in previous investigations, or sparcely treated in widely diverse and varying contexts.

In terms of securing the necessary and relevant data for this study the methodological procedure employed has been of a generally two-fold nature, that is, by reference to both bibliographical material and clinical experience. In regard to bibliographical material the author has attempted to search out all relevant and applicable sources of data pertaining to "terminal illness" and "death" not only in books and journal articles, but also in unpublished reports which have come to his attention. In so doing, the author has found the most practical and effective means of searching out his reference material is that of first examining various library card catalogues under the subjects of "terminal illness" and "death"; and then, having found those books or journal articles which appear to be relevant, to further examine their respective indexes and tables of contents in an effort to secure an idea as to

which pages in these publications would be most meaningful and helpful to the study at hand. While the author has found innumerable sources of data for this study by this means, much of it has been of a strictly "devotional" nature and, as a result, is not listed in the bibliography as its content was found to be of a rather uncritical, sentimental and generally poor nature. Thus, only those books and articles which the author felt to be of meritorious quality are included in the bibliography of this study. In regard to clinical experience the author has been engaged as an assistant chaplain for the past eight months at the Massachusetts General Hospital working in conjunction with the Department of Psychiatry in a program of calling on "dying" patients and their families in an attempt not only to provide pastoral support, but also to attempt to better understand the conflicting dynamics which arise in human behavior when the fact of death comes to be realized in one's personal and present experience. In this regard the author has found this experience to be invaluable in helping him to better understand and present in this study a more detailed, personal and first-hand evaluation of the problems which are met by all who face the crisis of death.

In order that we may arrive at a balanced presentation and a comprehensive understanding of the manifold problems

before us, this study has been divided into four "central" sections or chapters. The first of these serves as a backdrop to the other three in that it is an analysis of contemporary man's outlook and reactions to the fact of death. The second of these central chapters seeks to investigate and understand the behavior patterns, attitudes and needs of the terminal patient in light of his own imminent death. In the third central section we seek to examine and understand the manifold problems encountered by the family in terms of their internal feelings, spiritual needs and relation to their dying relative. And in the last of these central chapters we attempt to better comprehend not only the "personal" problems faced by the pastor in the context of his terminal ministry, but also, his many responsibilities to patient, family and congregation in light of the interrelationship of all within the Christian parish family.

But, at this point, however, we must take account of the enormity and complexity of the task before us and realize that just as no man is ever able to penetrate the totality of death's mysteries, so too, the scope of this thesis is not all inclusive and can only present a limited investigation into the manifold problems arising in the context of the terminal setting. Therefore, those problems beyond the scope of this thesis and the projections for further study will be treated in the concluding chapter.

And by way of definition, a "terminal" patient is herein considered as one for whom nothing more can be done in terms of medical service, and is therefore, diagnostically, embarked on the road to imminent death.

In beginning this investigation, however, it should be noted that this thesis does not purport to be a definitive study of the manifold problems encountered in the context of terminal illness and death, but rather hopes to serve as a means whereby this often neglected and crucial area of life may come to be better understood and more realistically appraised.

CHAPTER II

DEATH AND CONTEMPORARY MAN

Physical death represents the inescapable end of every human life, for in the created order of nature all living organisms decay and perish with time. The very fact of birth itself carries with it the subsequent necessity of death in order that the cycle of nature may run its course from "ashes to ashes and from dust to dust." That "in the midst of life we are in death" becomes abundantly clear from the facts of organic chemistry, wherein it is shown that man becomes inevitably involved in the process of dying from the very moment of his conception, for "the lifelong process of increasing the sources of energy is contending with an exorable process of breaking down of energy,"[1] the result of which can be none other than physical extinction. Man may, of course, postpone his death by means of supra-conservative health measures or gain reprieves through legislative action, but, in the final analysis, the sands of time run out and man returns to the inert matter from whence he came. As the Book of Common Prayer so vividly describes the life cycle:

> Man, that is born of a woman, hath but a short time to live, and is full of misery. He cometh up, and is cut down, like a flower; he fleeth as it were a shadow, and never continueth in one stay. 2

And so, while the length of days given to any man may vary

considerable, ultimately there comes a time when the bloom of life fades and the eternal makes its just and certain claim upon the ephemeral and transitory.

How each man relates to the fact that death is certain essentially determines his basic personality constitution as a man. That the ultimate finality of death extends its terminal reverberations back into life as a positive source of anxiety over non-being[3] necessitates that man come to terms with his own mortality in one way or another. Thus, whether he like it or not, each man must come to grips with the fact that he will one day die, if he is to live a productive and meaningful life free from unnecessary anxiety and self-pity. For as Dr. Tillich rightly discerns, "And if one is not able to die, is he really able to live?"[4] Therefore, in those who manifest a degree of personality disintegration at the time of death, or even more, at the thought of death, we are able to perceive the outcroppings of a supra-naive dealing with the basis of human existence.

Thus, while certainty of result, psychologically, tends to add stability to the individual's adjustive process by giving him a sense of controlled security over his future, the certainty of mortality has paradoxically the opposite effect, for it threatens to destroy that which the individual holds most dear, his life. What is more, the certainty of mortality gives rise to feelings of total

abandonment wherein the individual sees himself, at death, being set adrift in a chaotic sea of uncertainty.

While it might appear, at first glance, that the introduction of God into the schema of death would assure the suppression of anxiety over non-being, this simply does not hold up in all cases. In short, the dilemma often remains even with God; for if God does exist, then man is troubled by the problem of guilt which he sees as a possible threat to his inheritance of eternal life; and then again, if God does not exist, then man becomes anxious for he is threatened by the problem of meaninglessness.[5]

Thus, it is not too surprising that while man lives in a world surrounded by death on every side that he consciously and/or unconsciously represses its reality due to its frustrating finality. In this way man is able to find a temporary peace of mind which covers over what C.D. Kean has called "man's most universal anxiety,"[6] that is, the fear of death. And as one of the verses from the song "Old Man River" points out, we may be "tired of living" but we are "afraid of dying."

Basically man's fear of death springs from three sources,[7] each of which poses a definite threat to his being for all demand that he prepare himself for an event entirely foreign to his present or past experience. And as man learns to adapt his behavior and to live out his days in terms of

his past experience, the fact that death is the "last experience" thereby affords no opportunity for adaptation. Thus, death produces an anxious fear of overwhelming proportions, for one cannot learn from his own death. He can but die!

The first source of fear regarding death stems from the thought of physical pain and suffering which generally accompany the dying process. All sorts of contemporary expressions are in evidence which serve to heighten this fear, such as, "the throes of death," "the death rattle," "the last gasp," "the cry of anguish," and so on. While these generalizations may be somewhat overstated and yield a portrait of death not all too consistent with the facts, in that most people usually find peace at the last either by entering a coma or by induced sedation, it is still not at all uncommon, and quite true, that many endure long hours of agony prior to the moment of death. In this context, judging from the contemporary attitude, it is fair to say that the fear of death often does not stem as much from the fact of extinction as it does from the "way" or "process" in which one sees himself dying. As Dr. Bowers expresses this: "Extinction itself is less feared then the process that brings about the progressive dissolution of the things that have been considered to be the acts of living."[8]

The second source of fear regarding death stems from

the thought of leaving one's loved ones behind. This creates an almost unbearable anxiety for the person involved, as it threatens to totally sever all of the meaningful relationships from which he derived security, happiness and internal stability. In essence, all that the person has lived for in terms of family and friends and the love which he has given and received will come to an abrupt end. And so, in this context, man fears death for it threatens to shuttle him off into a chaotic unknown where the contemporary cry "love is life" and "life is love" is no longer applicable. Therefore, if man can find no meaning in life beyond that which he himself puts into it and derives from it in terms of transitory relationships, then the thought of death becomes an interminable burden for it promises to destroy everything that ever mattered.[9]

The third basic source of fear regarding death stems from the thought of entering an "unknown" realm of one sort of another. And as man throughout the ages has generally feared that which he cannot comprehend, the thought of death utterly paralyses him. He cannot by any means conceive of himself in a state of non-being, for to do so is to go counter to all his experience. But yet he knows this to be an inevitable outcome. As a result, he attempts to allay his anxiety by erecting illusionary defenses. "He tries," as Tillich says, "to create for himself a memory in a future

which is not his" and "imagine a continuity of his life after the end of his time and an endlessness without eternity."[10] The attempt being made here is the triumph over meaninglessness, for unless a workable and satisfactory solution is derived to counter or in some way deal with the fact of death, then the anxiety becomes intolerable.

Unfortunately, however, contemporary man has taken the all too easy short cuts of repression, denial and purely illusionary thinking in order that he may find peace of mind. Rather than facing the fact of his mortality and attempting to search out its meaning, contemporary man has essentially evaded the issue or thought, on the other hand, that he has come up with "lasting" defense mechanisms for tempering his anxiety. That these defenses will ultimately fail is never taken into account, and when they do, "the last state of that man becomes worse than the first (Luke 11:26)."

One of the most common temptations is for man to buy religion in the form of "eternal life insurance," and/or further to repress the reality of death lest it upset his present pseudo-security. The apparent success of this repression and misdirected use of religion is that it gives him temporary relief from his anxiety. Chances are that when death occurs in this individual's family that it will be taken in the same pseudomorphous manner, for in light of his prior dependance on repression to cope with the realities

of life, the only "safe" course of action to allay the anxiety of the present crisis is further repression. Thus, the delusional system continues as a reverberating circuit of defense against the very fact of life's transitory nature. The individual flips the coin of life and death, as it were, under the naive assumption that he can evasively cheat death by calling "heads I win, tails you lose." The fallacy in this assumption is that he does lose at one time or another due to the ephemeral nature of repression and the absolute certainty of his own death. At this point utter chaos ensues, unless, of course, he dies suddenly and is thereby excused from ever facing death. Surprisingly enough, many people operate under just this so-called "death-wish" as is evident from the commonplace statement: "When I die, I hope it's quick because I don't want to suffer." And in this context suffering means unconsciously, more often than not, the agony of a confused and anxious mind rather than the pain of physical decay.

Denial may also appear in a form which, in the first instance, gives the impression that the individual has made a perfectly satisfactory adjustment to the fact of his own death. While he speaks in what seem to be quite rationalistic terms about the contemplation of death, his focal point is continually directed away from himself and projected onto others. In this manner he avoids a "personal"

involvement with death. Denial of this type is in terms of biological and social conceptions of immortality.[11] Those holding to the biological view continually stress their hope of living on in terms of the "family tradition." They see in their children little "mirror images of themselves" which will somehow insure them a life everlasting. Or again, there are those who hold to the social view of immortality. These individuals picture themselves as somehow never really dying, for they have "left their mark" and go on eternally by means of their name being "indelibly inscribed on a book or memorial plaque." Generally, those holding either of these views do so at a point in life completely divorced from death, and when in a terminal state are confronted with such ideas find little consolation in them. At this point they desire answers of a "personal" nature and find themselves concerned with the question, "But what is going to happen to me?"

Related to these two foregoing attitudes is the defense mechanism which denies any interest in immortality of any sort. While this may come as somewhat of a shock to many who contemplate the joys of an ethereal heaven or who simply cannot conceive of themselves in a state of non-being, the attitude is still prevalent within our culture. Essentially it may be characterized by the "live for the moment" and "eat and drink for tomorrow you may die" attitude.

Those holding this view conceive of their present existence as a quite sufficient package for the realization of all that can or will ever matter. Not only do they see eternal life as so much extra baggage, they frankly admit they have no desire for it, even if it does exist. "One life," they state, "is perfectly sufficient to satisfy all my desires. When I die, that is it; I want and ask for nothing else." Others may perhaps vary this line of thought by considering all discussions of death as "morbid," but in any case, they would give the impression that otherworldliness contains no interest or appeal for them.[12] But once again, it must be realized that those holding to such an eschatological orientation generally do so at a point in life seemingly unrelated to their own death. And when, in the last days, they approach the door of death, their naive philosophy gives way. And so, like those holding to the social and biological view of immortality, they ask, "But what is really going to happen to <u>me</u>?"

In this context, then, it may be said that the close proximity of death brings out in every man an internal wrestling with the "real" issues of existence, regardless of the degree to which he has previously repressed them or denied their presence or necessity. Thus, for those who evade a realistic dealing with the fact of their own mortality, either by denial, repression or illusionary thinking, the

terminal process can create a flood of anxiety wherein the "sting of death" is felt in all its terrifying proportions. And as one terminal cancer patient so vividly expressed just these feelings to me, "The anxiety is killing me!"

But yet, contemporary man continues to avoid the fact of death lest it upset his present pseudo-security. In spite of this, however, man is driven by a curious fascination to look into the mysteries of death, provided, of course, he stays at a safe distance. He delights in hearing of gory war stories and in reading murder mysteries, for being detached from him personally, he can, at one and the same time, satisfy his inherent curiosity and close the book of "fictitious" happenings. Thus, he writes off all death as unreal or confined to the "other fellow." Dr. Irion characterizes man's interest in a "detached" viewing of death in this fashion:

> ...we seek to satisfy the natural curiosity and fascination which death holds for every man by an interest in detached death, such as semi-hourly violent demises of TV robbers and rustlers, spies, and private eyes. There is sufficient unreality in such dramatized death to render it...temporary, innocuous, and superficial because everyone knows it is not real. 13

That this sense of unreality attached to death has permeated our entire cultural framework is all too evident. An appraisal of the terminological and institutional matrix of contemporary American society reveals that no one ever "dies," but rather, the expression is that he has "passed

away" or "departed" as if this were only an extended vacation from the complexities of life. Hospital personnel when asked the whereabouts of a patient, who has died unknowingly to the inquirer, respond that he has "left" or "gone", as if he had returned home or been transferred to another ward. Physicians reporting the sad news to a family following a fatal accident respond with "I'm sorry" or "we did all that was humanly possible", as if the words "the patient is dead" carried a little too much emphasis. And then again, family and friends expressing their consolation respond with "we feel so bad" or "we know how you must feel", but never mention "about what."

What is more, the fact of death has been so neatly repressed that we seldom, if ever, hear anyone speak out on the subject in polite social conversation, lest it be in the spirit of joking, and even then, it never ceases to jangle the nerves of many so-called "well-adjusted" people. Quite in line with this unspoken social taboo is the remark of Alexandra Del Lago, the movie star of Tennessee Williams' play, Sweet Bird of Youth, who echoes the cry of contemporary man's fear, denial and resistance to the thought of death when she says:

> Whether or not I do have a disease of the heart which places an early terminal date on my life, no mention of it ever. No mention of death, never, never a word on that odious subject. 14

Moving into the institutional framework of death more directly, in terms of burial procedure, we find an even more profound evidence of repression and denial. Mortuaries have become funeral "homes", as if this in some way could erase the fact of death and somehow instill a last fleeting spark of "life" by its "home" atmosphere. Our "beloved departed" are glamorized with cosmetics and specially tailored clothing and then "set to rest" in an expensive hermetically sealed casket, lest the worms somehow break through and find them ill-attired for this auspicious occasion. And, in all of this, death has been by-passed through a false optimism which transforms "mortician" into "grief-therapist"; and in the final analysis, it brings forth a spirit of transitory loss with fixed attention not upon the person who has died, but rather, upon the mourners who have therapeutically paid the price to forget. As one astute observer of the contemporary scene remarks in this regard:

> Our cultural creed is optimism at all costs--its slogans, "Life is for the living," and "Business as usual." We embalm the dead with neo-Egyptian reverence, at exorbitant costs, to pay the price of forgetting. We shift insupportable sorrow and fear, to financial sacrifice and adulation of the marble mausoleum. 15

It is not only in terms of burial practices, however, that contemporary man pays exorbitant prices to forget, or better yet, "cover-up" the fact death is slowly creeping up on him. As it was observed in an earlier context that

terminal reverberations project themself back into life, the resultant manifestation to allay the anxiety therein caused shines forth in the millions that are spent each year on cosmetics to "cover-up", as it were, the simple fact that man does grow old and die. Clothing designers, in an attempt to preserve the fountain of youth, reduce "midrift bulge" and "bolster up the bust-line" in hopes that their creations will enlist the comment, "Why, she doesn't look her age at all!" But, in spite of all this, "the old grey mare ain't what she used to be" and all the soft drink commercials to "think young" and join the "Pepsi generation" cannot retard the shifting sands of time, for ultimately the "golden bowl" will be broken.

In this context it is interesting to note that when the wrinkles become too prominent and retirement becomes compulsory that society unconsciously feels threatened and acts to preserve its defense of youthful vitality. Thus, the contemporary social concern is to create "leisure towns" and "retirement centers" wherein those in their "twilight years" can be neatly lumped together, lest their presence "pollute" the mainstream of life by causing contemporary man to perceive his own future death being presently realized in them. And so, it is rationalized that older people desire the company of their brethren under the unconscious sentiment that when one is no longer able to produce he is somehow a

threat and useless token in the subway of energetic and youthful vigor.

While, in all of this, it must never be overlooked that a normal and healthy fear of death is quite essential to the preservation of life,[16] one must be continually on his guard against the development of over-protective and neurotic manifestations of this inherent fear. In other words, while safety councils, preventive health measures and medical research all have a constructive role to play within the cultural framework, contemporary man must be careful in his ultimate appraisal of death lest its slogans "to fight cancer with a check-up and a check" be subtly transformed into "kill the killer" campaigns, as if death itself could be eradicated through sufficient funds and more fully developed research.

In conclusion, then, contemporary man is faced with the fact of death as have been his ancestors throughout the ages. Ultimately he "must" die, whether in life he has chosen to repress, deny, take illusionary flights of imagination or meet squarely the fact of his mortality. Thus, it is in this relating to the fact that death is certain for each of us that we encounter the crux of the problems arising out of terminal illness, problems which have contingent bearing not only upon the pastor but also upon the patient and the family, as all these people are related to and create a reflective impression and influence upon the totality of the

Christian parish family in which they live. And it is to this interrelated influence and responsibility of Christian people one to another that St. Paul makes reference when he says, "...so we, being many, are one body in Christ, and everyone members of another." (Romans 12:5)

Therefore, having this chapter as a backdrop for the understanding of contemporary man's outlook on death, we will proceed to deal critically with the basic pastoral problems encountered in terminal illness by the patient, family and pastor. To this end, it is hoped the pastor may along with his people come to realize that "while in the midst of life we are in death" the "sting of death" can be transcended by a life centered in Christ, whereby the ephemeral takes on the eternal through the indwelling of the Holy Spirit, the realization of which enables man to die, physically and spiritually, that he may truly live both in this life and in the life to come.

FOOTNOTES

[1]M.K. Bowers and others, Counseling the Dying (New York: Thomas Nelson and Sons, 1964), p. 2.

[2]The Book of Common Prayer, "The Order for The Burial of the Dead," p. 332.

[3]W.E. Hulme, The Pastoral Care of Families: Its Theology and Practice (Nashville: Abingdon Press, 1962), p. 117, citing Tillich's ontology of anxiety in Courage to Be (New Haven: Yale University Press, 1952), pp. 32-64.

[4]Paul Tillich, "The Eternal Now," The Meaning of Death, H. Feifel, editor (New York: McGraw-Hill Book Company, 1959), p. 32.

[5]James A. Pike, Beyond Anxiety (New York: Charles Scribner's Sons, 1953), p. 114.

[6]C.D. Kean, Christian Faith and Pastoral Care (Greenwich, Connecticut: Seabury Press, 1961), p. 110.

[7]Felix Marti-Ibanez, A Doctor Looks at Death," Reprinted from the March 1964 issue of The Reader's Digest, p. 2.

[8]M.K. Bowers and others, op. cit., p. 37.

[9]C.D. Kean, op. cit., p. 110.

[10]Paul Tillich, Systematic Theology II (Chicago: Chicago University Press, 1957), 69.

[11]R.E. Buxbaum, "The Protestant Ministry to the Dying in the Hospital Setting" (paper read at the retreat of the ministers of the Presbytery of Alamo, Texas, November 9, 1963), p. 5.

[12]J. Baille, And The Life Everlasting (New York: Charles Scribner's Sons, 1933), p. 5,6.

[13]P.E. Irion, "In the Midst of Life...Death!," Journal of Pastoral Psychology, XIV (June, 1963), p. 66.

[14]T. Williams, Sweet Bird of Youth (New York: Signet Books, 1962), p. 37.

FOOTNOTES

[15]D. Cappon, "The Psychology of Dying," Journal of Pastoral Psychology, XII (February, 1961), p. 35.

[16]M.K. Bowers and others, op. cit., p. 38.

CHAPTER III

THE TERMINAL PATIENT

The terminal patient, whether he be confined to a hospital bed or passing his last days or months within the familiar surrounding of his home, cannot help but contemplate to some degree the imminence of his own death. That this internal wrestling with the contemplation of death is inevitable stems from the very fact that pain and illness of any sort tend, even in the non-terminal patient, to give rise to vague and apprehensive visions concerning the possibility of death and its nature. That these internal rumblings manifest themselves in even a healthy person who is merely undergoing a yearly physical check-up can be seen from such nervous comments, outwardly made in the spirit of joking, as, "Say Doc, do you think I"ll live?," or "What are my chances this time?" What happens following this initial encounter with the possibility of death depends to a great degree upon the individual involved, that is, he may repress, deny, resort to illusionary modes of thought, become terrified, or meet squarely this "fact" of life, as we have observed in the previous chapter. And as we are presently dealing with specifically "terminal" patients, some of whom realize the gravity of their situation and others who do not, it is the general aim of this chapter to deal with

their variant behavior patterns, attitudes and needs in the face of death to the end that those who come into contact with them will have a better understanding of the dynamics involved.

Basically one can distinguish three distinct categorical attitudes or behavior patterns to be found in and among terminally ill patients, that is, those who do not know they are at the threshold of death, those who realize that death is imminent but are unable to accept this fact, and finally, those who consciously recognize the seriousness of their situation and are willing to discuss its implications for their life.[1] While these three categories are not all-inclusive in themselves, they do, however, provide a general framework from which we may venture forth into a more critical and detailed investigation of the problem at hand.

As for those terminal patients within this first category, who are unaware of their condition, the problems arising from the "consciousness" of the imminence of death may not, it would seem, be manifested to any considerable degree unless, of course, the patient is somehow informed of his condition either by accident, intimation, or through verbal communication on the part of his physician, family, clergyman or others who are attending to his present needs. What is often overlooked, however, is the simple fact that as any illness progresses the patient, whether informed or

not as to the precariousness of his plight, eventually comes to inherently realize the seriousness of his situation and the fact that death is near. In this context a sixty-five year old terminal cancer patient remarked to me: "When you get in the shape I'm in you'd know you were dying even if they didn't tell you. So it doesn't do any good for people to pretend I'm not dying. I know it. How could I help but know!" This fact, in itself, then raises the problem of whether or not a patient should be told the truth about his terminal state from the beginning. But as our concern in this chapter is with the patient and his problems, the weight of responsibility for "truth-telling" rests with the pastor who must make his own ethical decision as to whether the fact of "knowing" would serve any significant purpose. And as we will deal with this crucial problem of pastoral responsibility in a subsequent chapter, we will now move on to discuss the attitudes, needs and behavior patterns of those terminal patients who fall into the second and third categories which have been set forth.

However, in order that we may come to a more comprehensive understanding of the two divergent behavior patterns which bring about a spirit of "rejection" in one patient and "acceptance" in another, it will be helpful for us, first of all, to take note of the basic psychological pattern which is evidenced in the terminal patient's personality structure

when the "possibility" of death has been perceived on the level of consciousness. In this respect it is necessary to realize that an individual, even in the face of death, tends to remain true to his basic personality structure, that is, the approach of death in no way transforms or remolds his inherent personality constitution as a man, a constitution which may have remained hidden to those about him throughout his lifetime.[2] In other words, if the individual was weak and met the issues of life only on their surface levels while in health, then he will become frustrated by the threat of death which he attempts to meet in the same pseudomorphous manner. And the result can be none other than his inability to accept the fact that he is "terminally" ill. And so, in this context, we might feasibly turn Dr. Tillich's aforementioned statement around and say,"And if one is not able to live, is he really able to die?", that is, when we bear in mind the conditioned patterning of basic personality structure. Thus, when we find what appear to be surprising differences in the behavior patterns and attitudes of terminally ill patients "...we must bear in mind that a breakdown of conscious controls reveals an individual in his basic unrestrained structure,"[3] a structure which has been, even if concealed, a guiding factor in this individual's life all along.

Turning now to a consideration of those terminal

patients who may be classified under the second category of being aware of their terminal state but yet unable to "accept" this fact, I think we can see, in the first instance, that this is a perfectly natural reaction as the "forced" contemplation of one's own death in the immediate future gives rise to feelings of apprehensiveness and unbelief, for the contemporary viewpoint characterizes death as something which only befalls the "other fellow." Thus, the very thought of one's own non-being, when one has for so so long a time been thinking in material existential terms, cannot help but arouse feelings of fear, unbelief and trepidation since it threatens to cast one into the chaotic abyss of the "unknown." As a result, the terminal patient comes to question and entertain doubts even in areas, such asreligious faith and medical integrity, where he has found for a lifetime a source of strength, confidence and hope. That this reaction of skeptical unbelief follows a generally consistent pattern among patients who have just learned of their terminal diagnosis, more specifically in those who have some time to live as is usually the case, is made clear by an observation of their initial responses.

In the majority of cases the first step taken by the patient upon learning of his "terminal" diagnosis is that of seeking additional information as to the nature and prognosis of his disease. He desires to know the amount of time

which he has left, the regions of his body which will become increasingly impaired, whether or not his last days will be spent in pain and anguish, and other questions of medical import.[4] While it might seem, at first glance, that the answers to these questions would serve to confirm his fate and thereby lay the foundation for a realistic dealing with his terminal condition, this does not follow in most instances, for the certainty of one's own demise within the forseeable future is never easily accommodated and almost always is met with great resistance and a frantic searching which "grasps at straws."

Thus, as a result of the anxiety aroused through the incorporation of his newly acquired and threatening knowledge, the terminal patient almost invariably reacts by "rejecting" his medical diagnosis under the assumption that his doctor or doctors have "obviously erred in their judgment." Consequently, his efforts are mobilized to find "new and better" doctors and treatment centers wherein he will find, as he is certain, "that he isn't going to die."[5] In this regard I am reminded of a sixty-two year old man with whom I spoke on the day of his admission to the Massachusetts General Hospital. He explained to me that he had been diagnosed as "terminal cancer" at his home town hospital which, as he noted, "isn't very up to date." He then went on to say that he was: "...sure that such a fine hospital as this will

discover that I'm ok. And if it's true that I do have cancer, which I doubt very much, then they'll be able to fix me up so I won't die."

The problem at hand, however, is the fact that such diagnoses are almost always confirmed. With this change in events the patient generally does a complete about face by resorting to "practitioners" of all sorts who would hold before him the "possibility" of cure either through "special treatments" or "incantations of faith." In any event this course of action usually leads to a pathetic despair and sometimes even violent challenge[6] of God's willingness to answer petitionary prayer. One might, in this context, take note of Jesus's words from the cross, "My God, my God, why hast thou forsaken me?" (Matthew 27:46) While these words echo the present feelings of the terminal patient in his moment of irreversible fate, the initial sense of desertion, helplessness and fear can be overcome (Luke 23:46). That is, if the individual has incorporated within himself a truly Christian outlook on death and has not used religious faith as a mere psychological crutch and cover-up for the real issues of life, then the "sting" of death can be transcended. The point here, of course, is that if repression, denial and an unaccepting attitude have been life's pattern, they will also be death's pattern.

While it is generally conceded that the terminal

patient who "denys his dying" has committed the unpardonable sin, as it were, and missed his last opportunity for "self-realization" and the chance for becoming a "whole person", in the terms of contemporary theological and psychological jargon, it is somehow overlooked that it is the "dying person who is dying" and not the interested therapist or friend who stands so near and yet so far from the event of death himself. As such, each individual simply because he is an "individual" has in inherent right to pass his last months or days or hours in the way in which he, himself, sees fit, for it is "his" life to live as well as "his" death to die. And as Dr. R.J. Fairbanks so descriptively remarks: "Each human being has the inalienable right to deny his dying if he so desires."[7]

Moving now to a consideration of those terminal patients who may be classified under the third category which has been set forth, we note a diversity of reactions. That is, those patients who are aware of their terminal state and are willing to discuss its implications generally react to their plight in one of four ways, none of which, it should be noted is all-inclusive.

In the first instance there are those patients who react to their terminal state in a spirit of quiet resignation and peace.[8] While they may not be Christians, they look upon death as a final opportunity for "summing up"

their lives in an orderly and dignified fashion, thereby fulfilling a life which may have been frought with failure and defeat. As one elderly gentleman with only a few hours to live told me: "Chaplain, I've never once succeeded in doing anything in my life well, but I'm determined to make this last act grand, glorious and dignified. If I don't, I'll have lived for nothing!" On the other hand, we must take note of these "committed" Christians who find peace at the last through a steadfast faith which has enabled them to work through the issues of life. While it is not to be denied that they experience initial fears and doubts as do their non-Christian brethren, they find, however, these frustrations to be of a transitory nature and transcended by a hope which "resurrects" them both physically and spiritually. In this regard I am reminded of another terminalcancer patient with whom I spoke, a woman of great faith, who put it this way: "You know the amazing thing is that I've received a new sense of courage and strength to bear up under all this pain; and I know, without a doubt, that God is with me and that I will be with Him very soon." And so, while we cannot conclude that persons of religious faith hold a monopoly on "peaceful termination", we can, however, note that persons of religious conviction generally find their last days to be less anxious, for as Cabot and Dicks note in this regard, "...to the religious person health, disease,

and death are incidental features of a continuous growth."[9]

Secondly, there are those patients who react to their shortness of days by a forthright impatience which may be due either to diminishing strength or a feeling that anything which will release them from their bond of inevitability will come as a great relief. In this sense they open themselves to the clergyman's pastoral ministry in hopes that his "last rites", sacramental or otherwise, will have their function realized in order that they may find an end to the frustration of "waiting."[10] In this regard I was told by a patient who had suffered long hours of agony: "Chaplain, isn't there something which you can do to hurry things up a bit. It's not that I'm afraid of dying. I would just like to end this torture and be with God. So please pray that I may die soon." And here my clinical work with terminal patients at the Massachusetts General Hospital would yield the general conclusion that dying persons of religious persuasion more often fall into this category than the next which is characterized by fear and threatening anxiety. Perhaps this is because the truly Christian person can "accept" the forgiveness of God, while others, being skeptical and uncertain as they have been throughout life, cannot.

Thus, the third type of reaction to the imminence of death is that of fear, trepidation and the threat of impending judgment. While confession or reception of the sacraments

may allay the anxiety for a time, the patient soon becomes fearful once again, often because of unresolved conflicts regarding death or a feeling that God is going to punish him.[11] That is, having experienced the "terror" at the death of one of his relatives or conjured up visions of a "fundamentalist God: who is waiting to cast him into hell for his sinful like, the patient becomes completely terrified in that he suddenly realizes that he is no longer the master of his own destiny. In this instance the "cry of anguish", so often associated with the dying, becomes a stark reality.

A fourth type of reaction to the imminence of death is that of total despair, wherein the individual sees his impending death as a final seal upon a life of failure, which, possibly for the first time, was beginning to show signs of promise. Thus, he feels cheated of his opportunity to make "his mark" and die with a sense of fulfillment at having accomplished something of worth. And as this type of person has usually placed ultimate value upon the "material" things of life, the threat of death engenders overwhelming despair as he cannot "do anything." In essence, his despair cannot be transcended for he knows nothing of "spiritual fulfillment," wherein the individual is judged in terms of personal worth and not material gain. Thus, death is synonymous with defeat, absolute and final defeat.

But as we are attempting in our study a thorough

analysis of those dynamics which are active in the terminal patient, it is necessary that we move beyond these external attitudes and delve into the inner consciousness of the patient, wherein we will find numerous problems of "guilt" adding to his already frustrating predicament.

That such "guilt geelings" invariably arise becomes evident for a number of reasons,[12] any one of which can serve to foster an unbearable degree of anxiety. In the first instance, many terminal patients look upon their fate as being self-inflicted, and as a result, spend their last days condemning themselves for not having lived in a "better" or more "cautious" fashion. And then again, there are others who feel they are being punished for not having lived up to their obligations in life, whether this be interms of care for loved ones or in not having done those things which society and the church considered to be "morally right." Many, however, simply feel guilty over the fact that they have not been more appreciative of life itself. In this context a clergyman expressing his "last" thoughts remarked:

> Perhaps one's greatest regret lies not in having been happier, more appreciative of the lovely things and simple experiences that compose normal life. What better thanks could one have rendered the creator? During the past year I have had an awareness of every beautiful thing in nature and of the goodness of man which could have made life rich beyond all power of expression. 13

There are still others, generally those who have been of an independent sort, who suffer grom guilt feelings over

"dependency", that is, they feel as though they are causing an undue hardship on those about them, as perhaps they are and have been told by an overly exhausted relative; and what is more, they may become unsettled over the fact that they are subtly forcing others to come to terms with death, and in this context feel they may be "resented" for it. But perhaps the greatest source of guilt stems from the unmanageable "wish" that one of those who is taking care of them were in their place. And as this is often a husband or wife or child, the guilt geelings mount into terrifying proportions, for while the patient recognizes that it is not "right" somehow to feel this way, he does nevertheless.

Thus, in light of these internally frustrating tensions, the terminal patient needs the supportive love and understanding of all about him not only to allay his guilt feelings but also to ease his sense of loneliness, wherein he is often held at bay by a "conspiracy of silence" which prevents any therapeutic outpouring of his inmost feelings. As such, his real "curse of fear" is not the uncertainty of his outcome beyond the portal of death, but rather, it is the "fear" of being "alone and forgotten" in his greatest hour of need.[14] Thus, at a time when he needs, more than ever, the warmth and understanding of those whom he loves and respects, there is often no one in sight to "listen" to those problems which press so heavily upon his mind. And as one

astute observer notes: "The normal goodbyes of a short trip are often denied the one who makes the long journey."[15] The reasons for this, however, must be left to the subsequent two chapters wherein we will investigate the reactions of both family and pastor to the terminal patient and his plight.

Returning now to our consideration of the terminal patient's inmost feelings in the face of death, we find, almost ironically, that he is more concerned for his loved ones than he is with himself. As Dr. John Baille notes in this regard:

> Let a good man be warned by his doctors that he has not long to live, and where do his first thoughts fly? I do not believe it is ever to his own case...or to the last agonies that he may soon have to endure. No, I think it is sometimes to the work he will leave unfinished; but even more commonly it is to the loved ones he must leave behind--to the difference it will make to them and the sadness it will bring to them. 16

And here I am reminded of a mother of five young children who expressed her feelings in this fashion the week before she died: "...at a time such as this all I can think of is my family...the hardships my children will face without me and the great loneliness and sorrow my husband will feel." In essence, then, the patient realizes that this is his last opportunity to set things aright in terms of both material provisions and interpersonal relationships. He sees these last days as a time for summing up his life in the context

of those meaningful relationships which have brought joy and happiness to his life; and in so doing, he comes to enjoy a feeling of personal worth wherein he can pass his last days or hours in a spirit of peace and internal satisfaction, for "...it is through this care for others that he comes to care about himself."[17] And while he may "sorrow" at the thought of leaving his loved one's behind, it is a sorrow which has in it an intrinsic degree of hope which looks forward to that day when he and his loved ones will be reconciled (II Corinthians 4:16-18). That the patient can find this "peace at the last" is dependent, however, upon God's love being mediated to him in and through those who minister to his needs and care for him, for as C.D. Kean so wisely perceives:

> The answer, therefore, to the underlying basis of fear--unsureness as to the meaningfulness of one's own life--is the love of the God who cares, who shares our miseries with us, who walks through every valley where we must go, and this love is made manifest through the patient support of the pastor (and here I would add family and friends as well), whose prayers and counsel are friendly, loving, supportive and above all concerned for the patient as a person. 18

As we shall see, however, in our subsequent treatment of both family and pastoral attitudes, to which we now proceed, the aforesaid type of ministry leading to the patient's "self-realization" in his moment of crisis is never one which is easily accomplished, for the "facing of death" tends to enlist even in well-meaning persons emotional reactions which are extremely difficult to control and often beyond the realm of conscious intent.

FOOTNOTES

[1]C.J. Scherzer, Ministering to the Dying (Englewood Cliffs, New Jersey: Prentice-Hall Inc., 1963), p. 104.

[2]A.A. Hutschnecker, "Personality Factors in Dying Patients," The Meaning of Death, H. Feifel, editor (New York: McGraw-Hill Book Co., 1959), p. 237.

[3]Ibid.

[4]R.J. Fairbanks, "Ministering to the Dying," Journal of Pastoral Care, II (Fall, 1948), p. 9.

[5]Ibid.

[6]Ibid.

[7]R.J. Fairbanks, "Editorials," Journal of Pastoral Care, XVIII (Summer, 1964), p. 96.

[8]R.J. Fairbanks, "Ministering to the Dying," Journal of Pastoral Care, II (Fall, 1948), p.8.

[9]R. Cabot and R. Dicks, The Art of Ministering to the Sick (New York: The Macmillan Co., 1936), p. 302.

[10]R.J. Fairbanks, "Ministering to the Dying," Journal of Pastoral Care, II (Fall, 1948), p. 8.

[11]Ibid.

[12]R.E. Buxbaum, "The Protestant Ministry to the Dying in the Hospital Setting" (paper read at the retreat of the ministers of the Presbytery of Alamo, Texas, November 9, 1963), p. 9.

[13]A. Hoben, "Then I Sleep," Journal of Pastoral Care, II (Summer, 1948), p. 14.

[14]C.D. Kean, Christian Faith and Pastoral Care (Greenwich, Connecticut: Seabury Press, 1961), p. 94.

[15]D.C. Beatty, "Shall We Talk About Death?," Journal of Pastoral Psychology, VI (February, 1955), p. 12.

FOOTNOTES

[16]J. Baille, And The Life Everlasting (New York: Charles Scribner's Sons, 1933), p. 64.

[17]Ibid.

[18]C.D. Kean, op. cit., pp. 94-95.

CHAPTER IV

THE FAMILY IN THE TERMINAL SETTING

The concerns of the family, as it functions in the context of one of its terminally ill members, are many and usually of a conflicting nature. Not only is the family faced with feelings of profound loss and often hopeless despair, but also by the presence of ambivalent feelings which serve to give rise to an internally frustrating sense of guilt. What is more, as many family members, due to a repressed fear of being "contaminated" by the dying, experience an anticipatory grief reaction prior to the death of their loved one which serves to cancel out the patient as "dead" before he actually dies, this, in turn, creates an unhealthy atmosphere from which both patient and family suffer heavy consequences. And while it might seem, at first glance, that it is the patient who faces the greatest ordeal in the context of the terminal setting, this is often not the case. For when we consider the magnitude of the emotional crisis faced by the family, their unresolved psychological and religious problems, their conflicts of identification with the dying person, their prospective loss of one who has meant so much, we come to realize that the terminal setting can be more disruptive and frustrating for those who live than for the person who dies. That this is true is all too

evident from the fact that many families find themselves torn apart, both physically and spiritually, by their confrontation with death. That these manifold concerns and problems can find a well balanced resolution depends, to a great degree, upon the insight, understanding and fortitude of all involved. And while it should be realized that not all families react to the crisis of the terminal setting in the same manner, it should be noted, however, that a generally consistent pattern of attitudes, needs and behavior patterns emerges in all families who are faced with the imminent demise of one of their relatives. Thus, the aim of this chapter is to investigate these attitudes, needs and behavior patterns to the end that we may come to a better understanding of the total dynamics involved.

One of the first problems faced by the family of a terminal patient is that of readjusting their thinking so that it is in line with the "reality" of the situation. That this is an extremely difficult task stems, as we have seen in a previous chapter, from the general contemporary outlook which tends to cover over the reality of death and make it into an "illusionary" villain whose hand strikes only those beyond the confines of our own family unit. As a result of this contemporary endoctrination against the "possibility" of the death of one of one's loved ones, the family upon learning of the terminal diagnosis of one of its

members generally reacts by denying the seriousness of the situation in order that not only their own security but also that of the family unit may be maintained. What is more, the defense must be maintained if only if be for the "good and encouragement" of the dying relative who the family feels must be given a "hope beyond all hope." And it is this type of nervous and illusionary sentiment which gives rise to such remarks, on the part of the family, as, "Now don't worry because you've got a fine doctor," or "We're all sure that the hospital where you're going will be able to help you." That remarks such as these serve to further frustrate the dying relative's already anxious state can be seen in these words from a terminal patient who told me: "Who are they (family) trying to kid. I know I'm going to die. I just wish they would face this thing with me."

Generally the second stage reached by the family is their realization that the death of their loved one is not only a possibility, but that it is a certainty. And with the realization of this fact comes a sense of impending emptiness and loneliness; and what is more, a feeling that part of their own lives is about to be taken from them. That this is a natural reaction stems from the fact that the act of loving tends to incorporate another human being into one's own self. Thus, for the family to sorrow and suffer in the context of the terminal setting is a natural phenomena and

for the family to deny that they are losing part of themselves in the death of their loved one is, in essence, to deny that they ever really loved. But, in this context, we must not be deceived by outward appearances, for often among those who have quarreled the most and seemed to have had the most casual of relationships there exists, in many instances, the deepest attachment and most profound love. And then again, those family members who appear to be bearing up under their burden with an unmatched bravery may, deep within, be troubled by feelings of great loss, despair and grief.[1] Thus, the imminent demise of a loved one calls forth a sense of grief which, in many individuals, often goes undetected, but yet remains to trouble the "inner man" of the bereaved. As Dr. Stephen Bayne observes in this regard: "Grief is natural; grief is also, inevitably, self-centered--we are sorry for ourselves at the loss of a loved one."[2] In this context, then, the contemporary song which speaks of "people who need people" shows itself to be a true characterization of human personality and selfhood, for with the loss of a loved one man finds that his own self has been irrevocably diminished. And here we find that John Donne perceptively realized this fact when he said: "Any man's death diminishes me, because I am involved in mankind; And therefore never send to know for whom the bell tolls; It tolls for thee."[3]

The problem here, however, is that each family member

perceives in the "bell's toll" not only the present loss of part of his life through the death of his loved one, but also, that day in the future when the bell will "finally" toll for him. In this regard the family's greatest crisis often springs from their own fear of death and internal doubts and anxieties, not only about practical and financial matters, but also from a transfer of their own unresolved psychological and religious problems onto their dying relative. This fact is manifested in the general concern, often this is a healthy concern, to have their loved one adequately prepared for his death by the pastor through reading, discussion and prayer, most notably by the family's own desire to be present during this preparation, a fact, in itself, which tends to give them the reassurance that their own death pangs will be met when their time comes. At this point one may note the close identification of family with patient, and a definite transfer of feelings from patient to family as well, in which the family symbolically participates in their loved one's suffering and death. As Dr. Kurt Eissler rightly points out in this context, "...in a true communication with the dying, one who loves will experience death with the one who dies."[4] And it is this fact of close identification in death, what might be called one's own "symbolic death," that gives rise to much of the emotional upset and unrest manifested in the family. Its outcroppings may be noted in the inward repul-

siveness felt by many family members at the sight of their dying relative as they symbolically see "themselves wasting away." This symbolic identification then reaches its zenith in the family's viewing of the body wherein each member in some fashion sees himself being lowered into the chaotic abyss of the grave and hearing that last handful of dirt fall ever so heavily and finally on the lid of his own coffin.

The family's problem of "symbolic identification" with their loved one generally gives rise to a third stage of behavior which is characterized by other troublesome feelings which stem from the very nature of love itself, in that where love exists there are also ambivalent feelings of contradictory emotion felt by the family in regard to their dying relative. Having been "forced," as it were, into a situation where death is plainly before them, not to mention many new and burdensome responsibilities and obligations, many family members come to resent their dying relative for putting them through such internal turmoil and external effort.[5] As a mother of a young boy about to die from injuries suffered in an auto accident two months before told me: "I hate to say this, chaplain, but you know it would have been a lot easier for everyone if Bob had been killed outright instead of lingering on like this...because he's going to die soon anyway."

That family members experience such feelings is often

due to their own weariness and exhaustion, wherein the demands of the patient are seen to be unreasonable, as in many instances they are. And under these circumstances family members often say and do things which at a later date are viewed by them as being most regrettable. What is more, as the concerns of the family as they gather about their dying relative range from practical matters of money and family security to the frustrating thought of funeral arrangements, it does not seem to unreasonable that this anxiety produces feelings of anger and resentment which are expressed "against" the dying relative for the "trouble" he is causing.[6] And here I am reminded of a young man, a boy whose father was at the point of death, who remarked to me: "Why does dad have to die now when I was about to start college? What am I going to do?...I guess I'll just have to go to work so the family can get by...Damn it, why did dad have to die now:" Thus, at a time when the patient needs more than ever the understanding and supportive love of his family it is often seriously lacking, in that family members troubled by ambivalent feelings of resentment and hate consciously and/or unconsciously avoid contact with the patient. The result of this is that the patient dies "alone and seemingly forgotten" without ever having had the opportunity to set things aright with those whom he loves most. And, on the other hand, family members miss the opportunity in laying

the foundation for a "healthy grief reaction," in that they sooner or later will find themselves burdened and obsessed by feelings of "guilt" for having responded to the patient in the manner in which they did.

The family's feelings of "guilt" represent what we might call a fourth stage in their behavior pattern of attitudes and constitute a definite threat not only to their adjustment in the context of the terminal setting, but also to their adjustment, in terms of grief work, following the death of their loved one. While most family members sincerely try to cope with the problems they encounter in the terminal setting in a "loving and understanding" manner, the presence of ambivalent feelings serves, however, to frustrate their efforts and thereby produces profound feelings of guilt and unhappiness following the death of their loved one. As C.D. Kean observes in this context:

> If a long protracted illness has preceded the death, there may be additional reasons for guilt, because few patients undergo long illnesses without showing some effects on the level of personality. They become unreasonable in their demands, or querulous, or non-communicative, or even exasperingly noble; and those who care for them cannot help feeling some resentment at the time, even though they may understand why the patients react as they do. When death occurs, the survivors remember these resentments and feel unhappy about them. 7

That these feelings of guilt over having said the wrong thing or having acted in the way in which they did produce an underlying anxiety which, in turn, creates more guilt can be seen in that many family members honestly feel their

attitudes or actions in some way contributed to their loved one's precarious position, or even, for that matter, to his death. And as one elderly woman told me in regard to her husband's terminal state: "Chaplain, if only I had taken more time to look after John I'm sure he wouldn't be dying now."

The family's guilt, however, may stem from many troublesome, but yet, uncontrollable thoughts which serve to plague the inner consciousness. Perhaps the most disturbing thought for a family member to manage, in that he loves the dying person, is his feeling of "relief" that it is someone else who is dying and not himself, for as Dr. M.K. Bowers notes: "'There but for the grace of God go I"is never completely eradicated from the consciousness."[8] But ironically enough, this same family member may feel "guilty" later on in a completely different fashion, that is, this time he may suffer pangs of guilt over being "alive" while one he loves so much is about to die. And in this context we hear such statements from distraught relatives as: "If only I could take his place" or "He's so young and has so much to live for...I've lived my life...Why couldn't God take me instead."[9] What is more, many family members, due to their close identification with their loved one in his death, feel spurred on to "get back with God" whom they have neglected for so long, and in so doing, feel very guilty over what

they know and sense to be a most hypocritical action.

We come now to the fifth and final stage in the family's behaviorial pattern, that of dealing therapeutically with their many concerns and problems not only that they may find for themselves an inner peace and security to move beyond and through the terminal crisis, but also that they may do this in an open fashion, thereby giving their dying relative the supportive love and understanding he needs in his last days. That this process of adjustive insight on the family's part can become extremely difficult is evidenced by the development, especially in long term terminal cases, of what Dr. Charles Bachmann has called an "anticipatory grief reaction," wherein as he states:

> The relatives may so much anticipate the death of a father or mother, for example, that, in their minds, they already buried him or her before he actually dies. They go through the usual grief process before death, and observers may report a tearless grief reaction. 10

While this, of course, may be beneficial in the long run for family, it serves, however, to sever the desperately needed bridge of supportive love between patient and family. And as a result, the dying "loved one" ceases to be viewed as such and becomes simply the "one" or "it" who is visited, and thereby he passes his last days "alone and forgotten."

While we have just noted the danger and complications of "anticipatory grief," we must note, however, that such a reaction can be put to good use if it is handled properly

by a pastor who has sufficient training and insight to employ what we will call, in this instance, "anticipatory grief therapy." By this term is meant a "working through" with family members, in conjunction with patient and pastor, of their feelings of guilt, ambivalence and impending loss; whereby the family may come to have insight into their inmost feelings, do much of their grief work prior to the death of their relative, and be enabled in the process to better give their dying loved on the support he needs. In essence, the goal of "anticipatory grief therapy" is to create a genuine spirit of openness wherein both patient and family can vent their internal feelings of doubt, hostility and apprehension and thereby enter onto the road of becoming a "whole person" even in the face of death. As Dr. Bowers remarks in regard to the "benefit" of "anticipatory grief therapy:"

> The communication with members of the family can have real benefit if they are willing to enter the conversation, expose their own feelings, and work through the problem with the patient. It is often a reassurance to the patient to know that there are some questions that do not have quick and easy answers, and that we all stand before death aware of our inadequacy. 11

All of this, however, is not to deny the fact that the family will find the last days of the terminal crisis to be difficult and sorrowful. That they will experience a profound grief at the death of their loved one is to be expected, for in the act of grieving man shows himself in his

naked humanity as a person who has loved and lost part of that which was meaningful for his life. But ironically enough, the act of grieving, in itself, possesses a definite therapeutic quality of "healing," whereby the family of the deceased has an opportunity not only to think through the loss of the one they loved, but also to recollect their thoughts and to begin life anew with a deeper and more profound understanding of its meaning both for the present and for the life to come. Grief, then, is a given with the human situation and its value lies in the way in which each individual uses its givenness, that is, he can sorrow as one who has no hope or he can sorrow as one who possesses a confident hope that death is but a portal through which one passes into the larger life of God's service.

To sorrow as one who has no hope is not to grieve but rather to let oneself become encompassed by feelings of neurotic guilt and externalized hostility, wherein an acute emotional instability prevents a healthy adjustment to the business of life. Such an unrealistic approach to the problems arising with the terminal process and death betrays an internal lack of confidence not only to deal with death, but also, an inadequate adjustment to the problems and questions of life. The resultant manifestations of this emotional instability lead ultimately to regressive tendencies wherein the individual either develops a childhood dependence upon

the rest of his family or becomes neurotically independent from the rest of the world, thereby cutting off all chances of working through his problems. But, in this instance, it is important to note, as Dr. Robert White points out, that "...none of these reactions are inappropriate in themselves: their inappropriateness lies in their excess."[12]

To sorrow, however, as one who does have hope is not to deny feelings of guilt and ambivalence, but rather, to have the strength and insight to seek help to move through these problems and to strive toward a new economy of happiness, wherein life gives meaning to death and death, in turn, gives a more profound meaning to life. This is, in essence, a therapeutic appropriation of grief wherein the individual moves ahead rather than regressing into infantile patterns of behavior. And as Dr. Edgar Jackson puts it:

> Grief is the emotion that is involved in the work of mourning, whereby a person seeks to disengage himself from the demanding relationship that has existed and to reinvest his emotional capital in new and productive directions for the health and welfare of his future life in society. 13

And this "forward movement" in terms of a new beginning is, in fact, the very heart of the Christian faith, for with trust and confidence in God's power to transform our lives we can begin again, in that "...our inner nature is being renewed every day." (II Corinthians 4:16) The implication of this dynamic fact is that in our suffering and sorrow we do have a hope and we need not become fixated at regressive

levels of guilt and hostility, but rather can move through these conflicts to the realization of a larger and more meaningful life both in this world and in the world to come. The implications of the positive relationship between religion and mental health are here quite clear, that is, when religion forms a secure basis for life and has moved beyond illusionary sentimentality.

Thus, having considered the crisis of the family in the context of the terminal setting, we now turn our attention to an investigation into the many conflicts, anxieties and responsibilities of the pastor's terminal ministry, in that the pastor is in a position to bring an inner peace and stability into an often frustrating and distressing situation, when and if, of course, he has come to terms with the fact of death himself.

FOOTNOTES

[1]Paul E. Johnson, Psychology of Pastoral Care (Nashville: Abingdon Press, 1953), p. 240.

[2]Stephen F. Bayne, Christian Living (New York: Seabury Press, 1957), p. 158.

[3]John Donne, "Devotions on Emergent Occasions," Seventeenth Century Verse and Prose, H.C. White, R.C. Wallenstein and R. Quintana, editors (New York: The Macmillan Co., 1951), p. 109.

[4]D.D. Williams, The Minister and the Care of Souls (New York: Harper and Brothers, 1961), p. 142, citing Kurt R. Eissler, The Psychiatrist and the Dying Patient (New York: International Universities Press, 1955).

[5]M.K. Bowers and others, Counseling the Dying (New York: Thomas Nelson and Sons, 1964), p. 57.

[6]Ibid, p. 63.

[7]C.D. Kean, Christian Faith and Pastoral Care (Greenwich, Connecticut: Seabury Press, 1961), pp. 105-106.

[8]M.K. Bowers and Others, op. cit., p. 34.

[9]R.E. Buxbaum, "The Protestant Ministry to the Dying in the Hospital Setting" (paper read at the retreat of the ministers of the Presbytery of Alamo, Texas, November 9, 1963), p. 11.

[10]C.C. Bachmann, Ministering to the Grief Sufferer (Englewood Cliffs, New Jersey: Prentice-Hall Inc., 1964), pp. 23-24.

[11]M.K. Bowers and others, op. cit., pp. 60-61.

[12]Robert W. White, The Abnormal Personality (New York: Ronald Press, 1956), p. 112.

[13]Edgar N. Jackson, Understanding Grief (Nashville: Abingdon Press, 1957), p. 18.

CHAPTER V

THE PASTOR'S TERMINAL MINISTRY

A pastoral ministry in the context of terminal illness demands much of a man for it necessitates not only a wealth of psychological stability, but also a securely grounded faith, the maintenance of which is no singularly easy task in light of the pastor's intimate relationship and close identification with the dying patient, his relatives and the fact of death, itself. As a pastor, his people depend on him for strength in the facing of death, they confess their sins to him relate their emotional problems to him, and in many instances, expecially in the context of the terminal setting, use him as an object upon whom they can safely transfer their own feelings of inadequacy, doubt, guilt, hostility and resentment. While all of this may be, and is in fact, therapeutically valuable on the terminal patient's and his family's behalf, it can often break a pastor who has not come to terms with his own internal feelings, needs, motivations and attitudes, and further has not dedicated himself fully to the high calling to which he has given his life. That the pastor is faced with a challenge and threat to his own "personal faith" by his participation in and with the death of others is evidenced by the following remark of a student chaplain working with the terminally ill

at the Massachusetts General Hospital. He notes: "I think of any individual's death as a human crisis which implies that the chaplain is involved in the event like all other people with feelings of helplessness, fear and loneliness."[1] That the pastor, in his terminal ministry, must and is responsibly bound by the nature of his calling to deal with and rise above his own personal inadequacies that he may become an "incarnate" instrument of God's love to his people as they pass through the "valley of the shadow of death (Psalm 23:4)" is, in fact, the "primary" responsibility in any pastor's terminal ministry. Thus, in light of the important and supportive role played by the pastor in the terminal setting and the inherent and potential problems encountered by him therein, it is the aim of this chapter not only to examine these problems, but also to bring to light many of the pastor's responsibilities, to the end that the pastor may be enabled to better understand the conflicting dynamics and responsibilities of his terminal ministry, and thereby be more adequately prepared to meet his people's needs as they relate to the terminal process and the fact of death.

Essentially, the greatest problem for the pastor in dealing with the crises of others as they arise in the context of the terminal setting is "himself," for as R.E. Buxbaum notes: "Every death, every sufferer, every sickness reminds us that we, too, must some day face these things."[2]

And while it may be an honor and privilege for the pastor to "walk the last mile" with a terminal patient, it can often become for the pastor not only a "frustrating and anxious" walk, but also a seemingly "unending" mile whose every turn is beset with new and personally threatening experiences. What is more, as the nature of the pastor's vocational calling demands that he walk an "extra mile (Matthew 5:41)" along the road of death, this being in relation to his pastoral support of the patient's family, many a pastor comes to view Jesus' commandment of an "unending and tireless agape" as either somewhat sadistic or totally unappreciative of his own personal level of endurance. This latter fact, of course, generally occurs in those pastors who either lack sufficient clinical experience and training or are somewhat unsure and apathetic about the motivations and responsibilities of their vocational calling.

In spite of these feelings, however, the pastor finds it an inherent responsibility and function of his ministry, nevertheless, to call upon those who are dying. But in light of the problems arising out of personal identification in and with the death of others, as we have previously noted, the simple act of the pastor's passing through the door of the patient's room, whether this be in a home or hospital setting, can serve to engender in him an almost uncontrollable degree of anxiety. In this regard a student chaplain at the Mass-

achusetts General Hospital told me: "My greatest problem in calling on dying patients is just building up enough strength and courage to walk into their room...I get to the door and often feel like running away or else I think of some other call I can make and go and do it, rationalizing the fact that this one patient didn't really need my call anyway...I think my greatest salvation, however, comes when there are family members present, for in talking with them I can indirectly participate in the crisis and thereby derive a feeling of satisfaction and worth." In regard to this chaplain's last statement concerning "ministering to the family" we can observe what might be called the "rationalized easy-out" taken by many clergymen, in that their anxiety level prevents them from entering into a meaningful relationship with the dying patient when, and if ever, possible. As a result, their "ministry to the dying" becomes ironically transformed into a "ministry to the living." And in this context I would cite the reflections of a hospital chaplain who perceptively remarks:

> How often I sat with family while the husband or wife or someone else was in the next room dying. This was easier for me. I could identify more comfortably, albeit with much discomfort, with their grief than with the person who was in the other room dying. I didn't know what to do or how to control my anxiety. 3

Bur ironically enough, ministering to the family instead of the patient may not always serve to allay the pastor's frustration and anxiety level; it may, in fact, tend to further

"heighten" his anxiety and frustration, in that family members often put more trust and confidence in their physician than in their clergyman.[4] Generally this is because of our contemporary culture's emphasis upon the "material act," wherein those who "produce" and "do something" of visible result come to be the most highly esteemed and valued. And while it is only reasonable that family members desire their dying relative's life to be saved, primarily in material terms and only secondarily, if need be in spiritual terms, it is often a blow to the pastor's ego and feeling of worth that his services come "second;" and what is more, it can be most disconcerting and frustrating for him if he has unwittingly confused the "values" of his calling with the "values" of the culture in which he ministers, and thereby feels threatened and helpless by his inability to "do anything."

Eventually, however, there comes a time when the pastor must meet the terminal patient in a face to face encounter. Sometimes this situation arises because family members are no longer present to "divert" his attention; or it may be because a sense of internal "guilt" pushes him into what he knows to be a "neglected" area of his ministerial service. And then again, we must not overlook the fact that many pastors, genuinely devoted to their calling, feel compelled and most readily welcome the "privilege" of giving their pastoral support to those facing the crisis of imminent death. But,

in any case, regardless of prior motivations, many a pastor finds his encounter with the terminal patient to be most frustrating and threatening. Often the pastor's frustration stems from the patient's inability to communicate or to think clearly; and as a result, the pastor finds himself in a position in which he must carry on a running monologue with his own inner man, continually guessing at the immediate concerns and needs of the patient and all the time wondering, in anxious uncertainty, if he has been saying appropriate and helpful things.[5] And then again, if the patient is responsive and "grills" the pastor with a host of questions concerning heaven, hell, God's judgment and the like, the pastor may become threatened by his own inadequacy at coming up with what he feels to be inappropriate and unintelligible answers. In other words, the pastor may find himself "bound and tied" by his own theological language which no one but he "really understands." As a result, he may feel he has "failed" his parishioner, and perhaps, he has. And while, in all of this, the pastor recognizes his responsibility to remain "objective" in order that he may be effective in his role, the weight of threatening anxiety and frustration may become so great that he finds a profound difficulty in controlling his emotions; and as a result, the only course of action open to him is to rationalize the benefits of a completely "objective pastoral ministration" into what we will call, for lack of a better

term, the "ecclesiastical defense syndrome." This "syndrome" is, in effect, a subtle method of shutting off any real interpersonal communication and sharing with the patient, wherein the pastor deludes himself into believing he is carrying on an "effective" pastoral ministry, for his emotional involvement no longer troubles him.

Let us, then, look briefly into the nature of the five most common forms[6] of this "ecclesiastical defense syndrome." First, there is the defense of "set-apartness," wherein the pastor uses his ordination as a shield to ward off any and all blows to his ego and feeling of self-worth. In essence, he comes to value his apostolic commission so highly that he has difficulty in valuing anything else, much less the sometimes "threatening" comments and attitudes of patient and/or family. Second, there is the defense of "ritualized action," wherein the pastor succeeds in isolating himself from his people by a means of formalized and traditional procedures, which he rationalizes are all that is necessary and right in providing "effective and valid" pastoral support. Third, there is the defense of "special language," wherein the pastor subtly eludes interpersonal communication, which might manifest his own inadequacies, by speaking only in "prayer book" or traditional theological language. Fourth, there is the defense of "special attire," wherein the pastor may use his clerical collar or some other mode of dress as a "wall"

separating himself from his people, at the same time, of course, feeling those about him are duly impressed and helped by his symbolic identification with God who he may, unconsciously, feel incarnates himself in the majesty of ecclesiastical finery. And last of all, there is the defense of "business," wherein the pastor subtly eludes relationships of depth by means of a "quick priestly blessing" which he, of course, feels he must pass on to each and every needy sufferer; and therefore, he views the effectiveness of his call not in terms of time spent, but rather in terms of the fact that "he" was there, if only for a fleeting moment.

It should be noted at this point, however, that none of the aforementioned "problems" in this chapter represent insurmountable hurdles, and also that none of the aforementioned "defenses" are, in themselves, entirely destructive of an effective terminal ministry, for it is in the pastor's recognition and understanding of these "problems" and "defenses" that he becomes better enabled to move through and beyond these obstacles into a more genuine pastoral relationship with his people. As M.K. Bowers perceptively notes in this regard:

> The pastor who puts his people first and is not afraid of them or their feelings is the pastor who can accept himself. He moves easily through life with little need for masks or defenses. He is the one who can sit quietly by the bedside for hours without saying a word, for he realizes that there are times when the protection of many words is unnecessary. For these persons even the ritualized

> acts are no walls,but rather are the avenues of approach thay may become the stepping stones into shared feelings and genuine communication. 7

Thus, for the pastor who has taken a deep introspective evaluation of not only the problems confronting him but also his attitudes and needs, and further has come to the realization that his ministry is Christ's and not his own, a stable and supportive terminal ministry can be effectually implemented wherein the needs of his people are met and his own faith and psychological balance remain stable. And this is, in essence, what St. Paul meant when he said: "Therefore, having this ministry by the grace of God, we do not lose heart (II Corinthians 4:1)."

We now turn our attention to a consideration of "pastoral responsibility." And here we will deal with not only the pastor's practical and spiritual responsibilities to his people, but also his practical and spiritual responsibilities to himself, for as a man of God the "image" he presents stems from the nature of his own "inner man" and has a contingent bearing upon all those to whom he ministers, for as we shall see, the pastor's effectiveness in all areas of his ministry, and especially in the context of the terminal setting, is directly proportional to his own psychological maturity and belief and trust in God's provident goodness.

As an ambassador of Christ, the pastor finds that he is in a paradoxically complicated situation in which he

represents God to man and, as such, must speak with an authoritative confidence; but yet, as a man, he is in no way in a privileged position with the God whom he serves, and therefore is responsibly bound to make this fact known to his parishoners, a task which necessitates a good deal of personal humility. But, in so doing, the pastor is also responsibly bound to maintain the integrity and "set-apartness" of his calling as a vessel through whom God's forgiveness, judgment, understanding and strength can find their way to man, and in the context of the terminal setting, to man whose questions and doubts demand every bit of pastoral support he can muster. That this is so necessitates that the pastor spend a sufficient amount of time, by himself, cultivating his own personal faith, the resultant manifestations of which he is responsibly bound to pass on to his people, if his ministry is to be in the fullest sense a "Christian" ministry. In this context R.J. Fairbanks notes: "Continually ministering to the sick is an extremely debilitating experience...It is important that we re-charge our 'spiritual batteries' from time to time."[8] If this is not done, the pastor not only fails in his responsibility to his people, but also in his responsibility to himself, for the man who is "internally spiritually dry" can offer nothing to those to whom he ministers, except, perhaps, his own despair, lack of trust in God's goodness and the burden of his own personal inadequacies.

On the other hand, an effective and responsible pastoral ministry demands of the pastor a disciplined and secure faith in the God through whom he derives confidence and trust in "his own abilities." As Dr. Rodenmayer views this need for the pastor's confidence in himself: "Self respect is a by-product of God's respect for us. Belief in oneself and one's abilities and one's usefulness is a good thing when it is offered to God who is its source."[9] Therefore, the effective and responsible pastor is he who meets his peoples' needs with a sure and set confidence in his ability to mirror God's love to his fellow man. That is, because he "knows and feels" the incarnate love of God in his own life, he is enabled to "radiate" this love to all those upon whom he calls. In short, it is the pastor's "responsibility", in light of his vocational calling, to meet his people as they face death with an "incarnate" trust and confidence which does not gloss over the "pangs" of death with superficial reassurances, but rather meets the fact of death squarely. Thus, in the final analysis, it is not until the pastor has become an "incarnate" instrument of God's love, however much internal wrestling and turmoil this may cause him, that he can be truly said to be carrying out an "effective and responsible" terminal ministry. And here I would commend to the reader the profound words of Chaplain Buxbaum:

> ...even God could not communicate his love until He did it in a person...In the same way, we cannot communicate the

> fullness of God's love until we become incarnate. We must all enter into relationship as persons of flesh and as one patient said to me early in my training: "Don't tell me how much God loves me, tell me how much you love me. Then I'll make up my mind about God." 10

The "responsibility" of the pastor also entails his placing a value in and having a respect for the "inherent and inalienable" rights of each individual to whom he ministers, for the authority of his calling in no way gives his the right to usurp that which belongs "solely and personally" to the patient in his facing of death, that is, the privilege of "initiating" all discussion as to the nature and meaning of death in and for his life. And while the pastor may know and feel that a sharing and discussion of the "problems" of death with the patient might lead to the patient's self-realization and a more peaceful termination, he still has no right to "force" this upon the patient, for as R.J. Fairbanks notes: "Ordination does not empower us to invade one's privacy merely in the name of righteousness." 11 And in this context we must continually bear in mind that what appears to be "unfulfillment" for one may may, in fact, be "fulfillment" to another!

But what of the patient who is uninformed as to the diagnosis of his "terminal" condition? Does he have the right to know and who is responsibly bound to tell him, if he has this right? Well much like the aforestated problem, each individual has the right to know the truth about

himself, if he so desires; for, after all, it is equally "his" life to live as well as "his" death to die. Thus, the physician who witholds the truth from his patient, when and if this is demanded, divests his patient of the essential mark of his "humanity" and transforms him into an "it" or "thing" who is being "repaired" as a machine instead of being "treated" as a human being, for as Joseph Fletcher rightly perceives: "Without their freedom to choose and their right to know the truth, patients are only puppets."[12] Thus, while it is the responsibility of the physician to pay the patient his due by means of truth-telling when and if this is asked, often the physician fails to live up to his "moral obligation," in that admitting to a patient the "terminal" nature of his condition the physician, in many instances, comes to feel a personal threat to his own abilities, and as such, is psychologically unable to "speak the truth." If this occurs, then the burden of ethical decision rests upon the pastor whose basis of decision must always be the Christ-centered "ethic of agape," wherein each case in individually considered and contextually evaluated from all sides, and in the end, "the truth is or is not spoken in love."

True pastoral responsibility, however, not only deals with the "immediate" crisis of a particular terminal illness, but also looks ahead and anticipates, in loving concern, those crises which lay ahead for those within the parish family.

For as the Christian faith views "life" and "death" as organically related components in a continual process of growth, it becomes an essential part of the pastor's responsibility to make this fact known to his people by means of an "educative preparation" for death, in order that his people may be prepared to realistically and confidently meet the problems encountered in the facing of terminal illness and death when they arise. This he may do through sermons, discussion groups, pastoral letters or any and all other effective means available to him; for this is as much a part of his "terminal ministry" as is his actual pastoral support of the dying and their families. The purpose of advanced preparation for the crisis of terminal illness and death is, in essence, to build up in one's congregation a "spiritual reserve" for the future. In so doing his parishoners may be given the opportunity to gain insight into their own attitudes, fears and beliefs, to the end that when they become personally faced with the crisis of death they may be more readily prepared to deal with their doubts and anxieties in an open and creative atmosphere. For the pastor to make this opportunity for true Christian growth possible is "...to show that this faith (our Christian faith and trust in God's continual presence) is a declaration about present reality, not only a promise of something beyond death."[13] And to realize this fact is to comprehend that every believing Christian is "already" a partaker in the eternal life of God,

of whom Christ is the first-fruits. As Jesus himself put it: "And this is eternal life, that they may know the only true God, and Jesus Christ whom thou hast sent (John 17:3)." It is the pastor's responsibility to communicate this not only to the dying, but also to the living!

In spite of this, however, it is important that the pastor recognize that his people must live in a world where evil is a realistic and ever present factor, a factor which inflicts disease, premature death and unexpected disaster upon all of mankind. For the pastor to attempt to skirt its reality and speak of evil as illusion is, itself, illusion, for the point of the Cross is that God lost his own Son because of the evil in this world. Therefore, the pastor must meet squarely the problem of "evil" in educating his congregation, if he is to adequately and realistically meet his peoples'needs. He is responsibly bound, both in his teaching and in his life, to convey the fact that God's love and presence transcend the sting of natural evil, that is, we are in God's hands "in spite of" the evil which may consume us, for this is the "strength" of the Christian's "resurrection" faith. And this is, in fact, the difference the pastor can show to his people between the "present evil age" with and without the living Christ in their lives; for while Christian man has but tasted the first-fruits of eternal life and evil is still very much with him, it is an evil which he need not

ultimately fear, for as St. Paul put it:

> Who shall separate us from the love of Christ? shall tribulation, or distress, or persecution, or famine, or nakedness, or peril, or sword?...Nay, in all these things we are more than conquerors through him that loved us. (Romans 8: 35, 37)

Thus, education and preparation of the congregation must go beyond speaking of death as an end of the road proposition and must continually strive not only toward meeting the problems of natural evil, but also stress the fact that to lead a Christian life is, in essence, to die daily, to the end that "physical" death and its contingent problems are but a natural expression and progression of the symbolically commonplace. In this regard Bishop Bayne remarks:

> To live with death, daily and without terror or morbid fascination--this is the Christian gift of healthy-mindedness. The thought of our own certain death and of our need to be prepared for it; our steady remembrance, in prayer and thought, of the dead whom we have "loved long since, and lost awhile;" our relaxed and mature balance in understanding of what lies beyond death; and our help to others in interpreting the great certainties of our faith--these are instances of what we mean by "living with death, daily." 14

Therefore, in light of this fact, it is the responsible duty of every pastor to prepare his congregation for both the problems of life and death since these are not mutually exclusive factors, but rather are organically related components in what a Christian may personally know and describe as a "resurrected whole, " the wholeness being God's love. With such an education to the meaning of human existence each parishoner will be somewhat better prepared to meet life and death without

indifference and repressed anxieties over the problem of human mortality. And as Cabot and Dicks "ideally" express the Christian outlook on both life and death:

> The Christian is not indifferent in the choice between life and death...He is certain of God and so whatever comes to him after he has done his best, must be good. He will win even when he loses. 15

FOOTNOTES

[1]Allan Reed, (ed.), "Ministering to Dying People" (paper is Research Project #2 of the Massachusetts General Hospital Summer School of Pastoral Care, June August, 1964), p. 6.

[2]R.E. Buxbaum, "What Does a Minister Do in a Sick Room" (paper read at the Bexar County Medical Society's Committee on Medicine and Religion, March 19, 1963), p. 2.

[3]R.E. Buxbaum, "The Protestant Ministry to the Dying in the Hospital Setting" (paper read at the retreat of the minister of the Presbytery of Alamo, Texas, November 9, 1963), p. 18.

[4]A.G. Elcombe and others, "Consultation Clinic: Fatal Illness," Journal of Pastoral Psychology, VI (February, 1955), p. 45.

[5]J.W. Steen, "Hindrances to the Pastoral Care of the Dying." Journal of Pastoral Psychology, IX (March, 1958), p. 28.

[6]M.K. Bowers and others, Counseling the Dying (New York: Thomas Nelson and Sons, 1964), pp. 67-68.

[7]Ibid, p. 69.

[8]R.J. Fairbanks, "Ministering to the Sick" (paper presented originally as one of the Starr Lectures before the Alumni of Trinity College, Toronto, September, 1947), p. 13.

[9]R. Rodenmayer, We Have This Ministry (New York: Harper and Brothers, 1959), p. 119.

[10]R.E. Buxbaum, "The Protestant Ministry to the Dying in the Hospital Setting," p. 20.

[11]R.J. Fairbanks, "Ministering to the Dying," Journal of Pastoral Care, XVIII (Summer, 1948), p. 10.

[12]Joseph Fletcher, Morals and Medicine (Boston: Beacon Press, 1960), p. 35.

[13]D.D. Williams, The Minister and the Care of Souls (New York: Harper and Brothers, 1961), p. 141.

FOOTNOTES

[14]Stephen Bayne, Christian Living (New York: Seabury Press, 1957), p. 156.

[15]R.C. Cabot and R. L. Dicks, The Art of Ministering to the Sick (New York: The Macmillan Co., 1936), p. 328.

CHAPTER VI

CONCLUSIONS, SUGGESTIONS AND PROJECTIONS

I. Conclusions

In the foregoing pages we have examined and considered the various reactions, needs, attitudes and behavior patterns of the patient, his family and his clergyman as they arise in and stem from the crisis of terminal illness, having as a backdrop for this investigation an analysis of the contemporary cultural attitude toward the fact of death and its effect upon the behavior and consciousness of modern man. This study has not only attempted to lay before the reader a critical analysis of the problems encountered in the terminal setting by patient, family and pastor, but also has endeavored to treat these problems in such a way that their "sources and causes" might come to be better understood, to the end that all who face the crisis of terminal illness may more readily appreciate and comprehend the conflicting dynamics which arise when the hand of death comes to be felt in the immediacy of one's present and personal life. And further, we have attempted to attain a unified focus in our study by drawing out and stressing the implications of the Christian faith for and upon those who, in their various capacities and roles, face the crisis of terminal illness and are thereby brought into a confrontation with not only

the fact of death, but also the very meaning and purpose of human existence. Thus, from this study three general conclusions can be drawn.

First, as long as contemporary men lets himself be swayed and duped by cultural endoctrination into thinking that death is only an imaginary villain whose hand touches only "other people," or continues, by conscious repression, to avoid a realistic dealing and personal confrontation with the facts of human mortality, he will find, and continue to find, that when the nearness or possibility of death does, as it inevitably will, come to be realized in the immediacy of his own present life that chaos, bewilderment and despair of paramount proportions will invariably arise, and plague him to the end of his days. And what is more, for the man who has made no personal accomodation to the fact of death life, itself, can only be lived in a superficial and shallow manner, for if one is not able to die, he is not able to live his life in its fullest and most meaningful sense.

Second, education as to the nature of the manifestations in one's behavior patterns, attitudes and needs which arise in the facing of death, whether this be one's own or that of someone else, and insight into these emotional manifestations, can serve to better prepare one for the crisis of terminal illness and death, in that when one has some knowledge of what to expect he is less likely to be totally

overwhelmed and devastated by the numerous conflicts which the facing of death engenders. And here, in essence, what matters is not the quantity or ease of living, but rather the "quality and depth" of living and one's insight into what is important, meaningful and necessary.

Third, while religious faith in no sense "guarantees" peace at the last and a successful summation and self-realization of life's ultimate meaning, it does, however, prove to accomplish these ends more readily than no religious faith at all; for it may be noted that an eschatological viewpoint of "salvation and God's goodness" tends to project its qualities back onto life, and thereby give meaning and purpose to that which, at the moment, may be painful, exasperating and bewildering. And it is in these terms that we find patient, family and pastor better enabled to move through their various trials and anxieties, together, in that they have a common focus and orientation in the person of Christ, who shares their common afflictions with them and promises to ultimately restore that which by life's perplexities or death's grasp is broken.

In the final analysis, no man can ever be fully prepared for the many and conflicting problems arising in terminal illness and death, simply because all men are fallible human beings. But, as Christians, it is our responsibility to labor daily that we may ever grow more fully in the love of

God made known to us in Christ and partially revealed to us in those human beings who become "incarnate" reflections of his love. And this is eternal life, that is, where life is a preparation for death, death a preparation for life, and God is seen to be the focal point in both.

II. Suggestions

As death inevitably comes to every man it is something which should be realistically planned for not only in terms of psychological adjustment, spiritual needs and life insurance, but also in terms of advanced funeral arrangements. While this may not be a very pleasant venture, it is an obligation which every individual owes to those whom he loves, in that advanced funeral arrangements, much like a will, can greatly lessen the burdens placed upon his family in their relationship with funeral director and clergyman at his death. How, then, can this be accomplished on the practical level here and now?

First, one should consult with one or more funeral directors. By far the majority of these men are most willing to assist in any way possible, that is, by answering questions related to embalming, customary burial procedure, and the items and services which comprise burial costs. When this is done, the individual will come to the realization that the funeral director is not out to exploit his clientele, but rather is genuinely interested in meeting the needs and

financial means of every person who comes to him for assistance. At this time one may find it convenient and advisable to select a funeral suitable with his financial means and thereby save his family from this undue and unnecessary hardship at the time of his death. What is more, most funeral directors offer an installment plan in which one can easily manage to pay off his funeral expenses during his lifetime, rather than letting this sudden financial outlay be placed as just one "more" burden upon an already troubled family at the time of his death. Far from being a morbid idea this, in fact, is quite a sensible and realistic action to take and alleviates many of the conflicting problems that arise concerning burial when no advance arrangements have been made. Furthermore, this is a perfect time to settle the clergyman question with the funeral director, in that the funeral director will know with whom he is dealing and can notify the clergyman in the instance that the family has not done so. This fact, in itself, can help not only the family, but also can serve to promote better relations between funeral director and clergyman.

Second, after the individual had made arrangements with the funeral director, he should consult with his clergyman, notifying him of his selection of a specific funeral director and the burial arrangements he has made. This will alleviate a great deal of confusion and unnecessary haggling

between funeral director and clergyman at the time of his death. In speaking with his clergyman he should state his preference as to what special hymns and prayers he would like, and further, write out a list of his wishes including policy on flowers, his favorite charities and all other specific details relating to the service which he wishes to be carried out, giving a copy of this to his clergyman, his closest relative, his attorney and his funeral director. Thus, when death occurs, both funeral director and clergyman, as well as all others concerned, will be able to carry out his wishes with minimal confusion and greater efficiency, thereby lessening the burdens placed on his family in their moment of grief.

III. Projections

In a study such as this, which is not all inclusive and only begins to scratch the surface of a broad and complex area, there are a number of unanswered questions and/or projections for further study which naturally arise out of this present investigation, in that their treatment lies beyond the scope of this paper. First, in a very real sense, there is the question of the physician's total role and function in the terminal setting, taking into account his many responsibilities and possible "moral conflicts," especially if such questions as "euthanasia" and "anti-dysthanasia" are given their due consideration as they most certainly will be in the

years to come. In another sense, there is the question as to the validity and effect of "spiritual healing," as employed by the pastor, upon those for whom medical science has given no possible hope for recovery, that is, does "spiritual healing" have a valid and rightful place as an alternative to and step beyond the procedures of medical science? And then again, in terms of pastoral care and support of the dying, is there not also an important function here for an expanded "ministry of the laity," wherein the ordained clergy might find a valuable and useful tool for supplementing their own limited time and energy, and thereby, in effect, provide a more meaningful and effective terminal ministry. Thus, while these questions and projections present, in themselves, only a brief and partial outlook into the nature of further study in this crucial area, they do, however, provide not only an appreciation for the complexities and vastness of the area of study in question, but also a base upon which further study may be begun, in order that death and the problems and questions related to it may come to be better understood and more realistically appraised in the coming years.

BIBLIOGRAPHY

A. BOOKS

Bachmann, C.C. Ministering to the Grief Sufferer. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1964.

Baille, John. And The Life Everlasting. New York: Charles Scribner's Sons, 1933.

Bayne, Stephen F. Christian Living. New York: Seabury Press, 1957.

Book of Common Prayer, American Edition of 1928.

Bowers, M.K., and others. Counseling the Dying. New York: Thomas Nelson and Sons, 1964.

Brister, C.W. Pastoral Care in the Church. New York: Harper and Row, 1964.

Cabot, R.C., and R.L. Dicks. The Art of Ministering to the Sick. New York: The Macmillan Co., 1936.

Cryer, N.S., and J.M. Vayhinger, editors. Casebook in Pastoral Counseling. Nashville: Abingdon Press, 1963.

Donne, John. "Devotions on Emergent Occasions," Seventeenth Century Verse and Prose, H.C. White, R.C. Wallenstein and R. Quintana, editors. New York: The Macmillan Co., 1951.

Eissler, Kirt R. The Psychiatrist and the Dying Patient. New York: International Universities Press, 1955.

Feifel, Herman. (ed.). The Meaning of Death. New York: McGraw-Hill Book Co., 1959.

Fletcher, Joseph. Morals and Medicine. Boston: Beacon Press, 1960.

Hackett, T.P., and A.D. Weisman. "The Treatment of the Dying," Current Psychiatric Therapies, Vol. II. New York: Grune and Stratton, 1962.

Hulme, W.E. The Pastoral Care of Families: Its Theology and Practice. Nashville: Abingdon Press, 1962.

Hutschnecker, A.A. "Personality Factors in Dying Patients," The Meaning of Death, H. Feifel, editor. New York: McGraw-Hill Book Co., 1959. Pp. 237-250.

Jackson, Edgar N. The Pastor and His People. Manhasset, New York: Channel Press, 1963.

_____. Understanding Grief. Nashville: Abingdon Press, 1957.

Johnson, Paul E. Psychology of Pastoral Care. Nashville: Abingdon Press, 1953.

Kean, C.D. Christian Faith and Pastoral Care. Greenwich, Connecticut: Seabury Press, 1961.

Michalson, C. Faith For Personal Crises. New York: Charles Scribner's Sons, 1958.

Mitford, Jessica. The American Way of Death. New York: Simon and Schuster, 1963.

Oates, W.E. The Christian Pastor. Philadelphia: Westminster Press, 1964.

Pike, James A. Beyond Anxiety. New York: Charles Scribner's Sons, 1953.

Rodenmayer, R.N. We Have This Ministry. New York: Harper and Brothers, 1959.

Scherzer, Carl J. Ministering to the Dying. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1963.

Temple, William. Nature, Man and God. London: Macmillan and Company, Ltd., 1960.

Tillich, Paul. Systematic Theology, Vol. II. Chicago: Chicago University Press, 1957.

_____. "The Eternal Now," The Meaning of Death, H. Feifel, editor. New York: McGraw-Hill Book Co., 1959. Pp. 30-38.

Weatherhead, L.D. Psychology, Religion and Healing. Nashville: Abingdon Press, 1951.

White, Robert W. The Abnormal Personality. New York: Ronald Press, 1956.

Williams, Daniel D. The Minister and the Care of Souls. New York: Harper and Brothers, 1961.

Williams, Tennessee. Sweet Bird of Youth. New York: Signet Books, 1962.

Wynn, J.C. Pastoral Ministry to Families. Philadelphia: Westminster Press, 1957.

Young, R.K. The Pastor's Hospital Ministry. Nashville: Broadman Press, 1954.

Young, R.K., and A.L. Meiburg. Spiritual Therapy. New York: Harper and Brothers, 1960.

B. PERIODICALS

Banks, Sam A. "Dialogue on Death: Freudian and Christian Views," Journal of Pastoral Psychology, XXXII (June, 1963), 41-49.

Beatty, D.C. "Shall We Talk About Death?," Journal of Pastoral Psychology, VI (February, 1955), 11-14.

Byron, R.I., and others. "When We Face The Dying: A Symposium," Christianity Today, II (February, 1958), 11-17.

Cappon, D. "The Psychology of Dying," Journal of Pastoral Psychology, XII (February, 1961), 35-44.

Elcombe, A.G., and others. "Consultation Clinic: Fatal Illness," Journal of Pastoral Psychology, VI (February, 1955), 42-53.

Fairbanks, Rollin J. "Editorials," Journal of Pastoral Care, XVIII (Summer, 1964), 95-96.

_____. "Ministering to the Dying," Journal of Pastoral Care, II (Fall, 1948), 6-14.

Gealy, F.D. "The Biblical Understanding of Death," Journal of Pastoral Psychology, XIV (June, 1963), 33-40.

Gibson, P. "The Agony of Dying," Frontier, III (Winter, 1960), 282-286.

Harris E.G. "The Physician, the Clergyman, and the Patient in Terminal Illness," Reprinted from The Pennsylvania Medical Journal, LIV (June, 1951), 541-545.

Hoben, A. "Then I Sleep," Journal of Pastoral Care, II (Summer, 1948), 11-15. Reprinted with permission from the Christian Century, from the issue of January 16, 1935.

Irion, P.E. "In the Midst of Life...Death!," Journal of Pastoral Psychology, XIV (June, 1963), 7,8,66.

Lindemann, Erich. "Symptomatology and Management of Acute Grief," A Paper delivered at the Centenary Meeting of the American Psychiatric Association, Philadelphia, May 15-18, 1944. Printed later in the American Journal of Psychiatry, CI (September, 1944).

Marti-Ibanez, Felix. "A Doctor Looks at Death," Reprinted from the March 1964 issue of The Reader's Digest.

Oates, W.E. "The Inner World of the Patient," Journal of Pastoral Psychology, VIII (April, 1957), 16-18.

Reeves, Robert B. "A Study of Terminal Cancer Patients," Journal of Pastoral Care, XIV (Winter, 1960), 218-223.

Rosenthal, H.R. "Psychotherapy for the Dying," Journal of Pastoral Psychology XIV (June, 1963), 50-56.

Steen, J.W. "Hindrances to the Pastoral Care of the Dying," Journal of Pastoral Psychology, IX (March, 1958), 27-32.

"Thanatology: Death and Modern Man," Time Magazine, LXXXIV (November 20, 1964), 92, 95.

C. UNPUBLISHED MATERIALS

Buxbaum, Robert E. "The Protestant Ministry to the Dying in the Hospital Setting," Paper read at the retreat of the ministers of the Presbytery of Alamo, Texas, November 9, 1963.

_____. "What Does a Minister Do in a Sick Room?" Paper read at the Bexar County Medical Society's Committee on Medicine and Religion, March 19, 1963.

Fairbanks, Rollin J. "Ministering to the Sick." Paper presented originally as one of the Starr Lectures before the alumni of Trinity College, Toronto, September, 1947.

Reed, Allan, (ed.). "Ministering to Dying People." Paper is Research Project #2 of the Massachusetts General Hospital Summer School of Pastoral Care, June-August, 1964.

Worcester, Alfred. "Concerning Ministerial Service to the Dying." Paper read at Dr. R.C. Cabot's Seminar at the Episcopal Theological School, February 24, 1925.